CHAPTER OVERVIEW

There is little doubt that the presence of drug and alcohol abuse has a phenomenal impact on the stability of the family. Substance abuse alone contributes to at least one-third of all child abuse reported. This chapter will examine substance abuse and its effect on individuals.

The use of drugs and alcohol, combined with the normal living stresses, creates distorted thinking which makes relationships more complex; uncontrollable emotions and unreasonable judgement complicate the family that may already bear various levels of dysfunctioning.

Nine classes of psychoactive substance are associated with both abuse and dependence:

- Alcohol;
- Amphetamine (also known as "speed") or similarly acting drugs;
- Cannabis (also known as marijuana and hashish);
- Cocaine (and its derivative "crack");
- Hallucinogens;
- Inhalants;
- Opioids;
- Phencyclidine (also known as PCP or "angel dust"); and
- Sedatives.

Distinction is made here between dependency and abuse.

Psychoactive Substance Dependence

The essential feature of this disorder is a cluster of cognitive, behavioral, and physiological symptoms that indicate that the person has impaired control of psychoactive substance use. The person continues use of the substance despite adverse consequences. Symptoms of the dependence syndrome include, but are not limited to, the physiologic symptoms of tolerance and withdrawal.

The symptoms of the dependence syndrome are the same across all categories of psychoactive substances, but for some classes some of the symptoms are less salient, and in a few instances do not apply (i.e., withdrawal symptoms do not occur in hallucinogen dependence).

Symptoms of Dependence

The following are the characteristic symptoms of substance dependence. It should be noted that not all nine symptoms must be present for the diagnosis of dependence, and for some classes of psychoactive substances, certain of these symptoms do not apply.

At least three of the nine characteristic symptoms of dependence are necessary to make the diagnosis. In addition, the diagnosis of the dependence syndrome requires that some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time, as in binge drinking.

1. The person finds that when he or she actually takes the psychoactive substance, it is often in larger amounts or over a longer period than originally intended. For example, the person may decide to take only one drink of alcohol, but after taking this first drink, continues to drink until severely intoxicated.

2. The person recognizes that the substance use is excessive, and has attempted to reduce or control it, but has been unable to do so as long as the substance is available. In other instances the person may want to reduce or control his or her substance use, but has never actually made an effort to do so.

3. A great deal of time is spent in activities necessary to procure the substance (including theft), taking it, or recovering from its effects. In mild cases the person may spend several hours a day taking the substance, but continue to be involved in other activities. In severe cases, virtually all of the user's daily activities revolve around obtaining, using, and recuperating from the effects of the substance.

4. The person may suffer intoxication or withdrawal symptoms when he or she is expected to fulfill major role obligations (work, school, homemaking). For example, the person may be intoxicated when working outside the home or when expected to take care of his or her children. In addition, the person may be intoxicated or have withdrawal symptoms in situations in which substance use is physically hazardous, such as driving a car or operating machinery.

5. Important social, occupational, or recreational activities are given up or reduced because of substance use. The person may withdraw from family activities and hobbies in order to spend more time with substance-using friends, or use the substance in private.

6. With heavy and prolonged substance use, a variety of social, psychological, and physical problems occur, and are exacerbated by continued use of the substance. Despite having one or more of these problems (and recognizing that use of the substance causes or exacerbates them), the person continues to use the substance.

7. Significant tolerance, a markedly diminished effect with continued use of the same amount of the substance, occurs. The person will then take greatly increased amounts of the substance in order to achieve intoxication or the desired effect. This is distinguished from the marked personal differences in initial sensitivity to the effects of a particular substance.

   The degree to which tolerance develops varies greatly across classes of substances. Many heavy users of cannabis are not aware of tolerance to it, although tolerance has been demonstrated in some people. Whether there is tolerance to phencyclidine (PCP) and related substances is unclear. Heavy users of alcohol at the peak of their tolerance can consume only about 50% more than they originally needed in order to experience the effects of intoxication. In contrast, heavy users of opioids often increase the amount of opioids consumed to tenfold the amount they originally used, an amount that would be lethal to a nonuser. When the psychoactive substance used is illegal and perhaps mixed with other substances, tolerance may be difficult to determine.

   NOTE: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP).

8. With continued use characteristic withdrawal symptoms develop when the person stops or reduces intake of the substance. The withdrawal symptoms vary greatly across classes of substances. Marked and generally easily measured physiologic signs of withdrawal are common with alcohol, opioids and sedatives. Such signs are less obvious with amphetamines, cocaine, nicotine, and cannabis, but intense subjective symptoms can occur upon withdrawal from heavy use of these substances. No significant withdrawal is seen even after repeated use of hallucinogens; withdrawal from PCP and related substance has not yet been described in humans, although it has been demonstrated in animals.

9. After developing unpleasant withdrawal symptoms the person begins taking the substance in order to relieve or avoid those symptoms. This typically involves using the substance throughout the day beginning soon after awaking. This symptom is generally not present with cannabis, hallucinogens, and PCP.

Criteria for Severity of Psychoactive Substance Dependence

Dependence, as defined here, is conceptualized as having different degrees of severity, and guidelines for mild, moderate, and severe dependence and dependence in partial or full remission are provided.

- Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning or in usual social activities or relationships with others.

- Moderate: Symptoms or functional impairment between "mild" and "severe."

- Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

- In Partial Remission: During the past six months some use of the substance and some symptoms of dependence.

- In Full Remission: During the past six months either no use of substance, or use of the substance but no symptoms of dependence.

Psychoactive Substance Abuse

Psychoactive substance abuse is a residual category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance.

The maladaptive pattern of use is indicated by either:

(1) The continued use of the psychoactive substance despite knowledge of having a persistent or recurrent social, occupation, psychological, or physical problem that is caused or exacerbated by use of the substance, or

(2) The recurrent use of the substance in situations when use is physically hazardous (i.e., driving while intoxicated).

The diagnosis is made only if some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time.

The person must have never met the criteria for dependence for this substance.

This diagnosis is most likely to be applicable to people who have only recently started taking psychoactive substances and to involve substances, such as cannabis, octane, and hallucinogens, that are less likely to be associated with marked physiologic signs of withdrawal and the need to take the substance to relieve or avoid withdrawal symptoms.

Examples of situations in which this category would be appropriate are as follows:

A college student binges on cocaine every few weekends. These periods are followed by a day or two of missing school because of "crashing." There are no other symptoms;

A middle-aged man repeatedly drives his car when intoxicated with alcohol. There are no other symptoms;

A woman keeps drinking alcohol even though her physician has told her that it is responsible for exacerbating the symptoms of a duodenal ulcer. There are no other symptoms.

More on Alcoholism

The alcoholic is an individual who compulsively uses alcohol even though it is destroying his/her life and who displays other symptoms, such as withdrawal, blackouts, and changing tolerance.

Alcoholism is a chronic, progressive disease, the same way that tuberculosis and diabetes are chronic progressive diseases. The disease is manifested by the compulsion to use even as the using destroys life. One can't become an alcoholic overnight anymore than one can contract any of the other progressive diseases overnight.

Effects of Alcohol/Chemical Dependency Upon the Family

Alcoholism (and drug addiction) usually manifests itself in a way that begins to affect the individual's life. It begins to affect his/her family. It is a family disease. The following information, while describing alcoholism, is also applicable to families experiencing addiction to other drugs.

Children who grow up in alcoholic families, spouses living with an alcoholic and parents with alcoholic children are all affected by a common thread with common symptoms. One of the most common is role reversal or taking on each other's functions or responsibilities. The entire family becomes negatively emotionally involved with the alcoholic. The alcoholic's addiction is with the bottle. The family, in their distorted roles, is addicted to the alcoholic. Thus, both have a disease.

None of the family members are primarily concerned with their own feelings or needs. Rather they live in perpetual dread of the alcoholic's behavior. All of their highs and lows are reactions to the behavior of the alcoholic. The longer the family lives in the condition, the more distorted their own emotions and general reasoning becomes. Distorted emotions and reasoning are common symptoms among members of a family where the disease of alcoholism is present. Several "categories" can apply, and as always one must allow for the fact that all are individuals.

Listed below are the most frequent categories and roles present in these families.

- **Chemical Dependent**: Goes through progression of guilt, shame, and a growing fear. They deny the problem by hiding it behind a wall of defense and remaining basically an adolescent in terms of emotional growth. This false front does give others in the family the illusion that they (the alcoholic) are "OK."

  It is said that it takes at least two to have an alcoholic. Examples of co-dependency include:

- **The Chief Enabler**: Person closest to, and most depended on by the alcoholic for their self worth. They are inevitably affected by the mood swings of the alcoholic. To keep a facade of normalcy, the enabler becomes more and more responsible for perpetuating the facade.

- **The Family Hero**: Usually, but not always, the oldest child. They see and hear more of what is happening in the family unit. They begin to feel responsible for the pain and turmoil in the family. They work hard to make things better, with a diligence to improve the situation. They often excel in academics, sports, or social organizations and bring favorable recognition to themselves and the family. They may appear quite mature, responsible, and healthy. However, hidden beneath the surface is loneliness, guilt, fear, and anger.

- **The Scapegoat**: Usually identified by the family as "The Problem." Usually the second child, he/she is quite often deprived of positive attention which is given to the hero and deprived of the immense energy which the parent with substance dependency may require. Quite often cute, humorous, and fragile, sometimes loud and precocious, the scapegoat gets attention in negative ways through disruptive and acting out behavior. Few see the fear and insecurity within the child. Scapegoats are often blamed for many of the family problems which are not their fault. "You would drink too, if you had a child like that," is often heard about the scapegoat. They come to act in a manner which will justify the accusations and often develop substance abuse problems themselves.

- **The Lost Child**: Tends to be withdrawn and a loner whose most valuable contribution is that he/she does not disrupt or demand attention. Because the family's attention is focused elsewhere, there is little attention available anyway. The lost child suffers loneliness even though loneliness is the most comfortable for them. As the family turmoil increases, the child often finds validation in fantasy. Without help it is almost impossible to find this validation in themselves, resulting in low self-esteem. They stand a good chance of becoming depressed and addicted to alcohol or drugs or becoming adults who are involved in co-dependency situations.

- **The Mascot:** Usually the family clown, the one who will do virtually anything to make the other members feel better. The mascot takes on the job of relieving tension and lessening crisis. They are very sensitive to the moods and needs of others. When mascots reach adulthood, they have trouble recognizing and meeting their own needs and have trouble dealing with stress.

It is important to remember that these roles are uncomfortable and confusing to anyone in them. The symptoms of one family member, while different from those of others, are all symptoms of a dysfunctional family. It is possible for children to switch roles or for one person to assume more than one role at a time. For

example, if the hero moves away, the family may respond by promoting another member as its hero.

Another trait of alcoholic or dysfunctional families is the presence of certain rules which prohibit a healthy family life and tend to perpetuate the dysfunction. These rules, while not stated, are none the less understood and enforced by all family members. These rules can be summarized as "Don't talk, don't trust, don't feel."

- **"Don't talk"** refers to the pattern of internalizing everything and not expressing feelings or thoughts to anyone. The family member understands that he or she should not disclose to anyone what is going on in the household - financial difficulties, drunkenness, physical/sexual abuse, or threats of divorce. If this rule is carried into adulthood, it makes honestly discussing virtually anything, of a personal nature, very difficult.

- **"Don't trust**" refers to the family member's learning that the only safe way to exist in an alcohol/substance distressed household is to not trust anyone. Others will prove to be unreliable. If this rule is carried into adulthood, it makes forming any sort of partnership with another person very difficult.

- **"Don't feel**" refers to the family member learning to deny and avoid his/her emotions. This rule is one way to avoid the emotional roller coaster of extreme highs and lows in an alcoholic household. Again, if this rule is carried as a coping skill into adulthood, it makes the individual poorly equipped to deal with life's emotional challenges. The adult child of an alcoholic is more likely to have inappropriate responses to events. For example, the person may have a rather cool or indifferent response to a personal or family tragedy but over respond to a book, television program or movie.

Why do families tolerate these conditions? It is because the conditions develop slowly, inch by inch, brick by brick. Role changes happen gradually and defenses are built slowly over a period of time.

The family's best defense against the emotional impact of alcoholism is gaining knowledge and achieving the emotional maturity and courage needed to put it into effect.

Recovery Resources

Successful recovery often requires a formal treatment program. The type of treatment program depends on the extent of the alcohol problem and the degree of impairment that has resulted. The two basic types of treatment programs are residential programs, which typically include detoxification services as needed, and outpatient programs.

- **Residential programs** provide extensive, short-term, 24-hour support to develop sobriety and encourage new patterns of social relationships, self-awareness, and personal development. Most residential programs have a length of stay of approximately 30 days. Alcoholism is characterized by chromaticity and

tendency toward relapse. Consequently, most treatment programs in an attempt to counteract those two characteristics, offer a period of extended association with the facility called aftercare. Aftercare usually consists of regular, scheduled return visits to the facility for group and/or individual counseling sessions. Aftercare normally lasts from three months to one year or longer. The longer a person remains abstinent, the better are his chances to continue to do so.

- **Outpatient programs** provide individual and/or group counseling to individuals who do not require, or who no longer require a residential program. The advantages of outpatient to residential treatment are obvious; the person is able to continue with his/her job and home life with little interruption. Outpatient is usually far cheaper than residential treatment.

  Two very different types of outpatient treatments are "intensive" and "supportive." In the intensive programs, the client usually attends classes, lectures, group therapy, and individual therapy sessions several times a week. Clients live and sleep at home and continue to work and maintain other responsibilities. Treatment sessions are usually in the evening. The length of the intensive outpatient program is usually longer than that of a residential program. Most programs are six to eight weeks. In a supportive outpatient program, the client attends the treatment facility on a regular basis; usually once a week for individual or group therapy sessions.

It is possible for a client to be transferred from one type of treatment program to another as his progress or lack of it determines. A person may need a combination of these types of treatment in succession or may only need outpatient services.

Although **Alcoholics Anonymous (AA)** is not a formal treatment program, it is often recommended to supplement professional treatment, and for some it may be the only recovery resource needed. AA provides ongoing fellowship and support for sobriety. AA was among the first methods to be successful in assisting large numbers of alcoholics to recovery. Part of its success is attributable to the premise that every member is a resource for every other member. In fact, the founding members discovered that helping each other remain sober was one of the best ways they had to remain abstinent themselves.

Al-Anon and **Alateen** are recovery programs for the spouse, friends and relatives of alcoholics (co-dependents). Al-Anon members say that those who love a practicing alcoholic become as sick as the drinker. The main purpose of participation in Al-Anon is not to help sober up the friend, lover, parent, child or spouse, but to free the co-dependent from their own destructive behaviors. Although it shares some of the same principles of recovery as AA, Al-Anon is a separate entity and is not affiliated with AA. While not necessarily a goal of Al-Anon, those in the program feel that if they become healthier and change how they behave, they can help the alcoholic to a new awareness of their behavior and possibly into recovery. They maintain that continued participation in the dysfunctional roles is destructive to families and the alcoholic.

Group medical insurance in Missouri is required to include coverage for treatment of alcoholism just like any other type of medical treatment. Group insurers are required to offer drug abuse coverage as an option. However, not everyone has "group" medical insurance. Those who have medical insurance could also have what are called "self-insured" policies or "individual" policies. Treatment is available even if one does not have group medical insurance. State funded programs provide services and charge on a sliding scale based upon family income and size. Often there is no charge or a very low charge.

Information regarding treatment resources and support groups can usually be found in local phone directories, through community health centers, and local ministerial alliances.

Check List for Symptoms of Alcoholism

Does the person...

- Need a drink the "morning after"?
- Like to drink alone?
- Lose time from work due to drinking?
- Need a drink at a definite time daily?
- Have a loss of memory while or after drinking?
- Find himself/herself (or others) harder to get along with?
- Find his/her efficiency and ambition decreasing?
- Drink to relieve shyness, fear, inadequacy?
- Find his/her drinking is harming or worrying the family?
- Find himself/herself more moody, jealous, or irritable after drinking?

Parent Questionnaire

The following is a questionnaire the Children's Service Worker can share with the parents if their child is suspected of abusing drugs or alcohol. Symptoms vary, but there are common signs the parent can watch for:

1. A dramatic change in personality. Does your youngster seem giddy, depressed, irritable, hostile without reason?

2. Do his or her moods change suddenly and without provocation?

3. Is your youngster less responsible about doing chores, getting home on time or following household rules and instructions?

4. Has he or she lost interest in school, extracurricular activities, especially sports? Are grades dropping? Have there been complaints of sleeping or being inattentive in class? Problems at school are common warning signs.

5. Has there been a change in friends toward a drinking or drug taking group? A youngster having problems with alcohol or drugs will abandon old friends and seek out those with similar attitudes and behavior.

6. Are you missing money or objects that are easily convertible into cash?

7. Does your youngster "turn off" to talk about alcohol or other drugs or strongly defend his or her right to use either or both? Abusers would rather not hear anything which might interfere with their behavior. People defend that which is most important to them.

8. Does the youngster stay alone in his or her bedroom most of the time? Does he or she resent questions about activities and destinations? Some secrecy and aloofness by teenagers is normal, but when carried to extremes, these may signal problems other than just growing up.

9. Has the youngster's relationships with other family members gotten worse? Does he or she avoid family gatherings which once were enjoyed? The primary family relationships are affected first.

10. Does your son or daughter lie to you or others? Lying about one's drinking/drugging is almost an infallible sign of a problem.

If the parent sees real evidence, such as the aforementioned signs, that his/her son or daughter is having a problem, don't hesitate; the parent should take some action; the worst thing to do, is nothing. It's easy for the parent to deny there is a problem, just as it is easy for the youngster to deny he or she is having a problem or even drinking or using other drugs. The Children's Service Worker should assist the parents in recognizing the problem and locating professional assistance.

Refusal Skills

One reason that many young people (and some adults) use alcohol and drugs is that they have difficulty refusing an offer if it is presented. Many people feel pressured to use substances. Pressure occurs when someone encourages or tries to force them to do something. The following is presented to assist Children's Service Workers and parents in their prevention efforts with young people.

There are at least five types of pressures used when trying to persuade someone to use substances:

1. Pressure to try substances includes the **simple offer.**

   The simple offer involves someone offering a drink, a pill, a snort, or any other substance as they might offer a soda, a stick of chewing gum, or a piece of candy. For example, "Would you like a beer?"

2. Pressure to try substances includes the **dare offer**.

   The dare usually involves a challenge of the youth's courage or sense of daring with statements like "Go ahead, I dare you" or "What's the matter, are you scared to?"

3. Pressure to try substances includes the **threat offer**.

   The threat implies that the youth will lose something of value if he/she does not use the substance. The loss could be anything of value, such as friendship or even the threat of harm. For example, "I won't be your friend if you don't try this."

4. Pressure to try substances includes the **indirect offer**.

   The indirect offer does not directly threaten the youth, but it implies a loss of stature if he/she doesn't participate. For example, "We're having a keg party. Be there or be square."

5. Pressure to try substances includes the **internal offer**.

   The internal offer appeals to the youth's internal needs rather than external or social needs. For example, "Oh, you're feeling down today. I have some pills that will take care of that." This offer implies that substances will take care of your feelings and problems in living.

Sometimes the pressure will be a simple offer and will progress to a dare, threat, etc.

There are good reasons for a young person refusing offers of alcohol or drugs. Here's a review of some of the basic ones.

1. For adolescents, all alcohol or drug use is illegal except for the use of medications as prescribed by a physician.

2. Substance abuse interferes with natural development physically, emotionally and mentally. The interference involves both short-term effects and long-term effects.

3. Substance abuse is destructive to family relationships. Substance abuse by one family member negatively effects all family members.

4. Substance use can become a preoccupation and interfere with other interests and your ability to function.

Once the young person has begun using substances it is not easy to just stop and start saying "no". Even if they know in their mind that alcohol and drugs are a negative influence on their lives and their future, it is not easy to change their behavior. However, there are certain skills and knowledge that can help them.

There are many different ways to refuse drug offers. Some of these techniques are:

1. "No thanks" Technique	"Would you like a joint?" "No thanks."
2. Broken Record	Repeat the same phrase over & over. "Would you like a joint?" No, thanks." "Come on!" "No, thanks." "Just try it, chicken!" "No, thanks."
3. Giving a Reason or Excuse	"How about a beer?" "No thanks. I don't drink" or "No, thanks. I'm going to play ball in a little while."
4. Walk Away	"Would you like to smoke some marijuana?" Say "no" and walk away while you say it.
5. Cold Shoulder	"Hey! Do you want one of these pills?" Just ignore the person.
6. Changing the Subject	Start talking about something else. "Do you want to smoke a cigarette?" "Come on. Let's get started with baseball practice."

7. Reversing the Pressure	Putting the pressure back on the person offering you the drug. "Do you want to smoke a joint with me?" "No, thanks. I thought you were my friend."
8. Avoiding the Situation	If you see or know of places where people often use drugs, stay away from those places.
9. Strength in Numbers	Hang around with non-users, especially where drug use is expected.

Drug Exposed Women and Infant Guidelines

Sections 191.725 through 191.745, RSMo, require the Division to collaborate with physicians/health care providers and the Department of Health in providing services to drug-involved women and infants.

This legislation (Senate Bill 190) was passed in 1991, implemented on July 1, 1992, and deals with prenatal and postnatal care and education for women and children regarding the harmful effects of alcohol, cigarettes, and drugs. The sections of the legislation that most directly affect Children's Division (CD) staff are discussed first.

- **Referrals to the Department of Health for Service Coordination**

  Effective July 1, 1992, physicians may refer to the Department of Health and Senior Services Bureau of Special Health Care Needs (DHSS/BSHCN) families in which infants may have been exposed to a controlled substance or alcohol. Maternal consent is not required for this referral. Specific requirements for referrals include:

  - Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in infant at birth, or

  - Confirmed toxicology test for controlled substances performed at birth on the mother or the child; and

  - A written assessment made or approved by a physician/health care provider, which documents the child is at risk of abuse or neglect.

  NOTE: A referral may also be made to DHSS, if the patient agrees, when a patient is identified prior to giving birth as having a high-risk pregnancy. No child abuse and neglect reports will be accepted for these referrals.

  The referrals to DHSS are made to their Bureau of Special Health Care Needs (BSHCN) area offices, or their central office toll-free number (1-800-877-6246).

- **The Children's Division's Role in Drug-Involved Cases**

  Division staff may become involved in drug-involved cases in one of the following ways:

  - A child abuse/neglect report is received in which the referral contains the above criteria and alleges that abuse or neglect is present. Services will be offered to the family and case opened, regardless of the outcome of the investigation, as the Division is mandated by the legislation to provide services when those criteria are present and a physician has referred the case for services.

  - Referrals made by physicians/health care providers to the CA/N Hotline which contain information regarding signs of drug involvement of the infant, but do not allege child abuse or neglect, are not accepted as child abuse and neglect reports. If calls of this nature are made to the Hotline, rather than as a referral to DHSS, CA/N Hotline staff will make the caller aware of the resource, and offer to transfer the call to the DHSS central office toll-free number. County office staff may follow this same procedure if a report is made to the local office. CD staff can make the physician/health care provider aware the DHSS "Service Coordinator" will involve Children's Service Workers in the planning and provision of services.

    If there is a "preponderance of evidence" finding, the Children's Service Worker will be the case manager for the case. If a preventive services case is opened, the case "Service Coordinator" and the worker will make a joint decision on which agency will take the lead in coordinating services to the family.

  - A physician/health care provider requests CD to conduct a home assessment prior to releasing the child from the hospital, or at the time the child is released.

    This home assessment is described in the section entitled "Newborn Crisis Assessment." The request may come through the Child Abuse/Neglect Unit or the county office.

  - A physician makes a referral to DHSS for service coordination without first requesting a home assessment from CD. The DHSS "Service Coordinator" will contact CD and DMH staff within 72 hours to involve them in providing services to the family. CD staff will provide necessary preventive services to the family, with the DHSS "Service Coordinator" taking the lead role.

"**Newborn Crisis Assessment"**

In these cases, a home assessment is requested by a physician or other medical personnel when they have serious reservations about releasing an infant from the hospital who may be sent home to a potentially dangerous situation. Many times a

drug-involved mother may continue using drugs, so an assessment of the home situation is needed prior to, or at the time the infant is released from the hospital. There may also be other non-drug related situations in which a physician/health care provider is concerned about releasing a newborn infant from the hospital. These referrals will only be accepted while the infant is still hospitalized. These generally involve an infant with medical problems when hospital personnel have serious concerns about risk to the child upon release from the hospital.

If the physician/health care provider is concerned about releasing the infant from the hospital, in the case of a drug-involved infant, and needs an assessment of the home before DHSS becomes involved (as it will be 72 hours before DHSS's initial contact), they may request assistance from CD. The request for a "Newborn Crisis Assessment" may be received by the Child Abuse/Neglect Unit or county office staff, and may be made prior to, or at the time of, the infant's release from the hospital. If there is an open Family-Centered Services or out-of-home care case, the county may elect to have the assigned worker complete the assessment rather than an investigative worker.

Although this will not be a child abuse/neglect report, county staff will handle the referral as an emergency, i.e., an immediate response to the request and the provision of information to the referring party in a timely manner (depending on when the hospital intends to release the infant). The assessment should include a recommendation as to whether the infant should be released from the hospital with the mother. If the worker feels the child should not be released with the mother, a referral to the juvenile court would be in order. The feedback will be provided by telephone or in person.

The Newborn Crisis Assessment shall, at a minimum, include the following:

1. Contact with physician/hospital personnel who made referral;

2. Visit with mother at the hospital, if she is still there, or at her home to determine her plans for caring for the infant upon release;

3. Observe the infant, assess the risk, and obtain information on any special needs;

> Note: If mother and child are in the hospital in another county, staff may enlist the assistance of CD staff in that county to visit the hospital and provide information to the county of residence.

4. Visit to mother's home, and/or home the infant will go to upon release, and do the following:

   a. See other children, if any, and assess the risk.

b. Evaluate support system which is in place, including family members, friends, etc.

Related Subject: Chapter 25, of this section, Diagramming Families For Assessment.

c. Determine other agencies involved with family and the extent of their involvement.

Related Subject: Chapter 25, of this section, Diagramming Families For Assessment.

5. Contact other agencies involved with the family to determine support, if appropriate; and,

6. Contact juvenile court if their involvement is needed.

If abuse or neglect of another child in the home is observed, generate a report of child abuse and neglect to initiate an investigation.

For drug related situations, information and copy of written assessment will be provided to DHSS/BSHCN's local "Service Coordinator" regarding the assessment and findings. Document in case files the information provided to the physician/health care provider. If staff later becomes involved with the family, or there is currently an open file, combine this information with the case file.

If after receiving the assessment, the physician makes a referral to DHSS, a "Service Coordinator will be assigned and CD will be mandated to provide appropriate preventive services to the family, although the DHSS "Service Coordinator" may take the lead role.

DHSS/CD Service Coordination

DHSS "Service Coordinators" are located in the 11 DHSS area offices. These staff will coordinate services to families referred by health care providers. They may also accept families referred by CD staff for care coordination services. This would include families whom CD staff has identified as needing treatment and who are willing to be referred to DHSS. CD staff may make referrals to DHSS "Service Coordinators" by referring directly to the coordinator assigned to their area, or by calling the toll-free number (1-800-877-6246).

Services from DHSS to the family will include a coordination of social services, health care and mental health services. They will notify CD and DMH within 72 hours and initiate services within the same time frame. They will complete an assessment and will determine the risk for or existence of CA/N and will make a hotline report if indicated.

The Department of Mental Health has developed Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state. A list of those programs is attached. The three types of CSTAR programs serve: 1) Women and children; 2) Adolescents; and 3) Adults. Though women can be served in the adult program, child care services are not available at those programs. The programs for women and children must provide child care and therapeutic activities for children while the mother participates in treatment. At those programs, first preference is given to pregnant women, second to women with children, and third to women without children. CSTAR treatment services are covered by Medicaid at all the facilities.

It will be important for CD and DHSS staff to collaborate on new referrals and coordinate service provision. This may include the initial home assessment to determine the risk for child abuse and neglect and to ascertain the needs of infants and families.

Sharing of Information Between DHSS and CD

It is critical that DHSS and CD share appropriate information with each other in order that services are provided to the drug-involved family. This should occur when cases are opened, as services are provided, and at the time of closing. Sharing of information with interdisciplinary teams formed to assist the Division in the investigation, evaluation, and treatment of child abuse and neglect cases is permitted under Section 210.150(2). Therefore, staff shall share any information which will assist in ensuring that families receive necessary services. The two departments have entered into an agreement regarding the exchange of information.

The Child Abuse or Neglect Hotline Unit (CANHU) will send to DHSS, on a daily basis, information received on drug-involved women and infants. When DHSS receives referrals from medical personnel, they may call CD to obtain information on prior child abuse and neglect reports and the status of open or closed Family-Centered Services cases.

On a county level, CD staff may share information with DHSS “Service Coordinators” obtained during investigations or during the provision of services which will assist them in ensuring that substance abusing women and their children receive services.

Closing Cases Referred By Physicians/Health Care Providers

The Division may have cases open in which a physician or health care provider completed a written assessment that the child is at risk of abuse or neglect. The Children’s Service Worker shall discuss the planned case closing with the DHSS service coordinator, and make a joint visit with the coordinator, when possible. They should then send their reasons for recommending closure in writing to the coordinator. At least 15 days prior to the planned closing date, the DHSS service coordinator will send a letter to the referring physician/provider (or hospital/clinic if physician is no longer involved with this family) with the following information (the worker should provide as much of this information as is available in their written recommendation to DHSS):

1. Reason for initial referral;

2. Services provided by all agencies involved with the family and whether they agree that CD may close its case;

3. How those services met the family's needs;

4. How risk of abuse or neglect to the child has been reduced;

5. Other agencies that plan to continue providing services;

6. Projected closing date; and

7. Request their written agreement that the case may be closed or that we will close the case on the specified date if we do not receive a response.

If there is no contact from the physician/health care provider, or the response is positive, the case shall be closed on the planned date. If a negative response is received, or there is a request for further clarification, the case cannot be closed.

Acknowledgments: Jim Schlueter, Program Specialist, and other staff at the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse, reviewed this chapter and submitted contributions.

Sources:

Missouri Department of Mental Health, Division of Alcohol and Drug Abuse, Curriculum Guide for Alcohol and Drug Education Programs (ADEP), 1988

Missouri Department of Mental Health, Division of Alcohol and Drug Abuse, Curriculum Guide for Alcohol Related Traffic Offenders Program (ARTOP), 1988

The Koala Center, P.O. Box 90, Lonedell, Missouri 63060, "Parent Questionnaire"

MEMORANDA HISTORY: CD04-79